CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2011 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE | |
|-----------|----------------------------------|---|---------|------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPLETED | |
| | | 155543 | B. WIN | G | | 06/23/2 | 2011 |
| NAME OF I | DROVIDED OD GUDDI IED | | - | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1425 G | RANT ST | | |
| | Y CREEK AT HUNT | | | | NGTON, IN46750 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| F0000 | REGULATORY OR | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | | r a Recertification and Survey. This visit | FO | 0000 | This Plan of Correction constit | utes | |
| | | estigation of Complaint # | | | the written allegation of compl | | |
| | IN00092175. | estigation of Complaint # | | | for the deficiencies cited. How | | |
| | 11100092173. | | | | submission of this Plan of Corr is not an admission that a defic | | |
| | Complaint # IN0 | 0092175- Substantiated. | | | exists or that one was cited cor | | |
| | • | iciencies related to the | | | This Plan of Correction is subn | | |
| | allegations are ci | | | | to meet requirements established | ed by | |
| | anegations are er | tod dt 1 111. | | | state and federal law. | | |
| | Survey dates: | | | | Hickory Creek at Huntington d | esires | |
| | June 20, 21,22,23 | 3, 2011 | | | this Plan of Correction to be | | |
| | | | | | considered the facility's Allega | | |
| | Facility number: | 000346 | | | of Compliance. Compliance is | | |
| | Provider number | | | | effective on July 15, 2011 | | |
| | AIM number: 10 | | | | | | |
| | | | | | | | |
| | Survey team: | | | | | | |
| | Vicki Bickel, RN | I-TC | | | | | |
| | Debora Barth, Ri | N | | | | | |
| | | | | | | | |
| | Census bed type: | | | | | | |
| | SNF/NF: 33 | | | | | | |
| | Total: 33 | | | | | | |
| | Canqua navar tam | | | | | | |
| | Census payor typ Medicaid: 32 | JC. | | | | | |
| | | | | | | | |
| | Other: 1 | | | | | | |
| | Total: 33 | | | | | | |
| | Sample : 10 | | | | | | |
| | These deficiencie | es reflect state findings | | | | | |
| LABORATOR | Y DIRECTOR'S OR PROV | TDER/SUPPLIER REPRESENTATIVE'S SIC | SNATURE | | TITLE | | (X6) DATE |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K67311

Facility ID: 000346

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE S | | | SURVEY | | |
|--|--|---|----------------------------------|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | ETED |
| | | 155543 | B. WING | | | 06/23/2 | 011 |
| | | | B. WII. | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | RANT ST | | |
| HICKOR' | Y CREEK AT HUNT | INGTON | | | NGTON, IN46750 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) | |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | AG REGULATORY OR LSC IDENTIFYING INFORMATION) | | ļ | TAG | DEFICIENCY) | DATE | |
| | cited in accordan | ce with 410 IAC 16.2. | | | | | |
| | Quality review completed on June 27, 2011 by Bev Faulkner, RN | | | | | | |
| F0157 SS=D | resident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuconditions or clinical ter treatment significant conditions or clinical ter treatment significant change in the facility as specified. The facility must a resident and, if known there is a change in reside State law or regular paragraph (b)(1) of the facility must resident and the facility must a resident and the facility must a change in reside State law or regular paragraph (b)(1) of the facility must resident and the facility must resident a | is in either life threatening cal complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the lown, the resident's legal interested family member lange in room or roommate excified in §483.15(e)(2); or ent rights under Federal or ations as specified in of this section. | | | | | |
| | resident's legal rep family member. | s and phone number of the presentative or interested ew and record review, the | EU | 157 | This Plan of Correction | | 07/15/2011 |
| | | · | 1.0 | 131 | constitutes the written allegation of compliance for the deficiencies | | 07/13/2011 |
| | = | notify the physician of a | | | | | |
| | condition change | e for 1 of 10 residents (| | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | NSTRUCTION | (X3) DATE SURVEY | | |
|--|---|------------------------------|----------|------------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DINC | 00 | COMPL | ETED |
| | | 155543 | B. WIN | | | 06/23/2 | 011 |
| | | <u> </u> | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | 1 | RANT ST | | |
| HICKOD | Y CREEK AT HUNT | INCTON | | 1 | NGTON, IN46750 | | |
| HICKOR | T CREEK AT HON | INGTON | | HONTH | NG 1011, 11140750 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | <u> </u> | TAG | DEFICIENCY) | | DATE |
| | Resident #12) re | viewed for physician | | | cited. However, submission of | | |
| | notification in a | sample of 10. | | | this Plan of Correction is not | | |
| | | • | | | admission that a deficiency | | |
| | Finding includes | · · | | | or that one was cited correct This Plan of Correction is | ıy. | |
| | I manig merades | · | | | submitted to meet requireme | nte | |
| | | | | | established by state and fed | | |
| | | linical record was | | | law. Hickory Creek at Huntin | | |
| | reviewed on 6/20 | 0/11 at 2:10 p.m. | | | desires this Plan of Correction | | |
| | Diagnosis includ | led but were not limited | | | be considered the facility's | | |
| | to: schizophrenia | a, chronic paranoia, | | | Allegation of Compliance. | | |
| | 1 ^ | ive pulmonary disease, | | | Compliance is effective on Ju | uly | |
| | 1 | ronary artery disease, and | | | 15, 2011. F157 It is the poli | • | |
| | 1 ** | • | | | this facility to notify attending | | |
| | tardive dyskines | 1a. | | | physicians and families/legal | | |
| | | | | | representatives of resident s | tatus | |
| | The "Nurses No | tes," dated 4/4/11 at 5:45 | | | changes immediately upon | | |
| | a.m., indicated R | Resident #12's oxygen | | | observation. What corrective action will be done by the | <u>-</u> | |
| | saturation (Sa02 |) was checked, due to | | | facility?No further omissions | of | |
| | ` | ions, and found to be 83% | | | physician or family/legal | <u> </u> | |
| | 1 - | s needed" oxygen was | | | representative notification ha | ive | |
| | | | | | been identified. The Director | | |
| | | vious order. No further | | | Nursing or Designee will revi | ew | |
| | 1 | on (SaO2) levels were | | | the twenty-four hour report a | | |
| | taken at that time | e. | | | focused charting at least five | | |
| | | | | | each week to ensure notifica | | |
| | On 4/4/11 at 9:0 | 0 a.m., the "Nurses | | | are completed.Licensed Nurs | | |
| | | the residents SaO2 level | | | will be inserviced on July 7 a | | |
| | | 2 LPM (liters per | | | July 8, 2011 by the Director of Nursing on the importance of | | |
| | 1 | | | | immediate notification of the | ı | |
| | 1 | signs were blood pressure | | | attending physician and | | |
| | _ | 6, respirations 18, | | | families/legal representatives | s | |
| | _ | degrees. No other | | | when a resident condition | | |
| | assessment was | completed. | | | changes. Following the inser | vice, | |
| | accessment was compressed. | | | | any nurse who fails to follow | | |
| | At 10:25 a.m., on 4/4/11 a physician's | | | | correct procedure of notificat | ion | |
| | 1 | | | | will be re-inserviced and | | |
| | order was received for labs to be drawn | | | | progressive disciplinary action | | |
| | 1 | aw and obtain urinalysis. | | | rendered. How will the facility | | |
| | There was no me | ention of the physician | | | identify other residents having | g tne_ | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|--|---|------------------------------|---------|------------------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DINC | 00 | COMPL | ETED |
| | | 155543 | B. WIN | | | 06/23/2 | 011 |
| | | 1 | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF | PROVIDER OR SUPPLIEF | ₹ | | 1 | RANT ST | | |
| HICKOR | Y CREEK AT HUNT | INGTON | | 1 | NGTON, IN46750 | | |
| | | | | | 101014, 11440730 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | | | DATE |
| | being notified of the SaO2 earlier in the | | | | potential to be affected by the | <u>e</u> | |
| | a.m., in the "Nurses Notes." | | | | same practice and what corrective action will be take | 2011 | |
| | | | | | residents have the potential | | |
| | At 12:00 p.m., a | n order clarification was | | | affected. No residents were t | | |
| | 1 | oxygen) mask at 2 LPM to | | | to be negatively affected.Wh | | |
| | 1 | ion above 88%. Again, | | | measures will be put into pla | | |
| | 1 * | the "Nurses Notes" the | | | ensure this practice does not | | |
| | | | | | recur?The Director of Nursin | | |
| | 1 " " | otified of the low oxygen | | | Designee will review focused | | |
| | saturation level. | | | | charting and the twenty-four | | |
| | | | | | report at least five days per water prior to the morning meeting. | | |
| | The "Nurses No | tes," dated 4/4/11 at 2:25 | | | change of resident condition | | |
| | p.m., indicated t | he residents SaO2 level | | | be reviewed by the | **** | |
| | 1 * | lunch. The oxygen mask | | | Interdisciplinary Team includ | ing | |
| | | LPM with SaO2 levels | | | the Administrator at that mee | | |
| | returning to 92% | | | | to ensure notifications were | | |
| | Teturning to 9270 |). | | | completed. Any licensed nur | | |
| | | | | | who fails to complete require | | |
| | 1 * ' | 4/4/11 the "Nurses | | | notifications will be re-inservi | iced | |
| | Notes" indicated | the resident's SaO2 | | | and progressive disciplinary action rendered as deemed | | |
| | levels to be at 92 | 2%-94% with O2 at 2 | | | necessary. Review of the nu | rsina | |
| | LPM. | | | | focused charting and twenty- | | |
| | | | | | hour report is an established | | |
| | On 4/5/11 at 1:3 | 0 a.m., SaO2 was 92% | | | ongoing responsibility of the | | |
| | per "Nurses Note | | | | Director of Nursing. How will | _ | |
| | per marses mon | cs . | | | corrective action be monitore | | |
| | 0 4/5/11 + 0.2 | 0 4 101 | | | ensure the deficient practice | | |
| | 1 | 0 a.m., the "Nurses | | | not recur and what QA will be into place? Results of the foo | | |
| | | the resident was | | | charting and twenty-four hou | | |
| | 1 - | levels were 92% on | | | report review will be forward | | |
| | 2LPM via nasal cannula. | | | | the monthly QA&A committee | | |
| | | | | | further review for 90 days an | | |
| | The "Nurses Notes," dated 4/5/11 at 11:00 | | | | until 100% compliance is | | |
| | a.m., indicated the resident's" breath | | | | obtained. The QA&A commit | | |
| | sounds were coarse through-out bilateral | | | | will then determine the need | for | |
| | 1 | _ | | | further monitoring.Date of | | |
| | 1 | eded respiratory treatment | | | Compliance: July 15, 2011 | | |
| | was given. O2 | Saturation was 92%, | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY | |
|--|---|------------------------------|------------|------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | ETED |
| | | 155543 | B. WIN | | | 06/23/2 | 011 |
| | | 1 | D. 1111 | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | 1 | RANT ST | | |
| HICKOR | Y CREEK AT HUNT | INGTON | | 1 | NGTON, IN46750 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
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| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | pulse 112, respir | ation 18 and irregular. | | | | | |
| | Resident weak ri | ight lower extremity | | | | | |
| | elevated warmth | and redness resident | | | | | |
| | responds with ve | erbal stimulation though | | | | | |
| | delayed". | | | | | | |
| | delayed . | | | | | | |
| | The physician w | as notified at this time | | | | | |
| | 1 1 | | | | | | |
| | | an immediate chest x-ray | | | | | |
| | | ong with an order for an | | | | | |
| | antibiotic to be s | tarted. | | | | | |
| | | | | | | | |
| | | 4/5/11, a call was placed | | | | | |
| | to the physician | regarding the resident's | | | | | |
| | condition per "N | urses Notes." | | | | | |
| | | | | | | | |
| | At 10:15 p.m., o | n 4/5/11 an order was | | | | | |
| | received to send | the resident to the local | | | | | |
| | emergency room | for evaluation and | | | | | |
| | treatment. | 101 0 / 010001011 0110 | | | | | |
| | li catillolit. | | | | | | |
| | The resident was | s admitted to the local | | | | | |
| | | 1 at 2:21 a.m., with | | | | | |
| | 1 - | · | | | | | |
| | ~ | ute mental status changes, | | | | | |
| | 1 - | ection with possible | | | | | |
| | | ypercarbia (high carbon | | | | | |
| | dioxide in the bl | ood), which is | | | | | |
| | improving". | | | | | | |
| | | | | | | | |
| | An interview with the Director of Nursing | | | | | | |
| | on 6/21/11 at 11 | :05 a.m., indicated she | | | | | |
| | was unsure of w | hy the resident was not | | | | | |
| | fully assessed. | Γhe initial thought was | | | | | |
| | 1 | had cellulitis in her right | | | | | |
| | | and that was why the | | | | | |
| | 15 Wei extremity | and that was willy the | | | | | |

000346

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|------------------------------|---------|--------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | |
| | | 155543 | B. WING | G | | 06/23/2 | 011 |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | RANT ST | | |
| HICKOR | Y CREEK AT HUNT | INGTON | | HUNTIN | NGTON, IN46750 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
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| | | dered. She also indicated | | | | | |
| | the urinalysis report prompted the physician to be called but there was no documentation. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | ey and procedure dated | | | | | |
| | * | and reviewed on | | | | | |
| | | d " the resident's primary | | | | | |
| | 1 2 | be notified immediately | | | | | |
| | | the resident's physical or | | | | | |
| | | . Examples of significant | | | | | |
| | | out are not limited to: | | | | | |
| | Signs and syn | nptoms of infection." | | | | | |
| | | | | | | | |
| | 3.1-5(a)(2) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| F0328 | | nsure that residents receive | | | | | |
| SS=D | special services: | and care for the following | | | | | |
| | Injections; | | | | | | |
| | Parenteral and en | | | | | | |
| | | ostomy, or ileostomy care; | | | | | |
| | Tracheostomy care Tracheal suctionin | | | | | | |
| | Respiratory care; | 9, | | | | | |
| | Foot care; and | | | | | | |
| | Prostheses. | | | | | | |
| | | ew and record review, the | F0. | 328 | F328It is the policy of this fac | - | 07/15/2011 |
| | facility failed to | provide respiratory | | | to administer treatments and | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|------------------------------|---------|--------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDING | 00 | COMPL | ETED |
| | | 155543 | B. WIN | | | 06/23/2 | 011 |
| | | <u> </u> | B. WIIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIEF | R | | | RANT ST | | |
| HICKOD | Y CREEK AT HUNT | INICTON | | 1 | | | |
| піскок | T CREEK AT HUNT | INGTON | | HOMIN | NGTON, IN46750 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
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| | assessment and i | nebulizer treatments for 1 | | | special services as ordered to | | |
| | of 1 residents (Resident #12) reviewed for | | | | the attending physician. Wha | | |
| | 1 | ratory care in a sample of | | | corrective action will be done | <u>by</u> | |
| | 10. | ratory care in a sample of | | | the facility? Resident #12 is | to oo | |
| | 10. | | | | receiving nebulizer treatmen ordered and respiratory | is as | |
| | | | | | assessments have been | | |
| | Finding includes | 3: | | | completed as indicated.Licer | nsed | |
| | | | | | Nurses will be inserviced by | | |
| | Resident #12's c | linical record was | | | Director of Nursing on July 7 | | |
| | reviewed on 6/20 | 0/11 at 2:10 p.m. | | | July 8, 2011 on correct | | |
| | | led but were not limited | | | assessment of residents req | uiring | |
| | " | a, chronic paranoia, | | | PRN oxygen or nebulizer | | |
| | 1 | - | | | treatments.Following the | | |
| | | ive pulmonary disease, | | | inservice presentation, any n | | |
| | 1 ** | ronary artery disease, and | | | who fails to follow the proced | | |
| | tardive dyskines | ia. | | | for administering treatments | as | |
| | | | | | ordered and completing | l bo | |
| | Physician orders | included "as needed" | | | appropriate assessments will re-inserviced and progressive | | |
| | 1 - | n and albuteral via | | | disciplinary action will be | | |
| | nebulizer. | ii and arouterar via | | | rendered as deemed | | |
| | nebunzer. | | | | necessary. How will the facilit | ty | |
| | | | | | identify other residents havin | | |
| | The "Nurses Not | tes," dated 4/4/11 at 5:45 | | | potential to be affected by the | <u>e</u> | |
| | a.m., indicated R | Resident #12's oxygen | | | same practice and what | | |
| | saturation (Sa02) |) was checked, due to | | | corrective action will be take | | |
| | ` ` | ons, and found to be 83% | | | residents have the potential | | |
| | 1 | s needed" oxygen was | | | affected, no other residents | | |
| | | , , | | | found to be negatively affect | | |
| | 1 ** ` * | previous order). No | | | What measures will be put in place to ensure this practice | | |
| | 1 | aturation (SaO2) levels | | | not recur? The Director of | uuca_ | |
| | were taken after | the application of the | | | Nursing or Designee will revi | ew | |
| | oxygen nor did t | he "Nurses Notes" | | | focused charting and the | | |
| | indicate the oxyg | gen flow rate. | | | twenty-four hour report at lea | ast | |
| | indicate the oxygen now rate. | | | | five days a week prior to mo | | |
| | On 4/4/11 at 0:00 a may the "Names | | | | meeting to determine if any | | |
| | On 4/4/11 at 9:00 a.m., the "Nurses | | | | resident required PRN oxyge | en or | |
| | | the resident's SaO2 level | | | nebulizer treatments. The | | |
| | to be at 91% on | 2 LPM (liters per | | | medical record of any reside | nt | |
| | minute). Vitals s | igns were blood pressure | | | requiring PRN oxygen or | | |

000346

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) | | | (X3) DATE SU | 3) DATE SURVEY | |
|--|----------------------|------------------------------|---------------------------------|--------|---|--|----------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLET | ΓED | |
| | | 155543 | B. WIN | | | 06/23/201 | 11 | |
| | | | b. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | RANT ST | | | |
| HICKOD | Y CREEK AT HUNT | INCTON | | | NGTON, IN46750 | | | |
| | - CICLLICAT HOINT | INGTON | | TIONTI | 101, 1140750 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | Ε (| COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE | |
| | 148/72, pulse 130 | 6, respirations 18, | | | nebulizer treatments will be | | | |
| | temperature 98.0 | degrees. No other | | | reviewed by the interdisciplin | | | |
| | assessment was o | completed. | | | team including the Administra | | | |
| | | 1 | | | at the morning meeting to en appropriate assessment and | Suite | | |
| | | | | | follow up was completed. Re | view | | |
| | A+ 10:25 a | 1/4/11 a physician's | | | of the nursing focused charting | | | |
| | | 1 4/4/11 a physician's | | | and twenty-four hour report is | - 1 | | |
| | | ed for labs to be drawn | | | established, ongoing | | | |
| | | w and obtain urinalysis. | | | responsibility of the Director | of | | |
| | No mention of th | e physician being | | | Nursing. Review of the | | | |
| | notified of the Sa | O2 earlier in the a.m. in | | | Medication Administration red | cord | | |
| | the "Nurses Note | es." | | | and Treatment record will be | l, for | | |
| | | | | | completed five days per wee four weeks, three days per w | | | |
| | At 12:00 n m ar | n order clarification was | | | for four weeks and then weel | | | |
| | _ | | | | for four weeks. How will | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | | |
| | · · | xygen) mask at 2 LPM to | | | corrective action be monitore | ed to | | |
| | | on above 88%. Again, | | | ensure the deficient practice | | | |
| | no indication in t | he "Nurses Notes" the | | | not recur and what QA will be | e put_ | | |
| | physician was no | tified of the low oxygen | | | into place?Results of monitor | | | |
| | saturation level. | | | | the medication administration | I . | | |
| | | | | | record and treatment records | s will | | |
| | The "Nurses Not | es," dated 4/4/11 at 2:25 | | | be forwarded to the QA&A committee for further review. | | | |
| | | ne resident's SaO2 level | | | After 90 days and 100% | | | |
| | * · | | | | compliance is obtained, the | | | |
| | | lunch. The oxygen mask | | | QA&A committee will determ | ine | | |
| | | LPM with the SaO2 | | | the need and frequency of fu | I . | | |
| | levels returning t | o 92%. | | | monitoring.Date of Complian | ce: | | |
| | | | | | July 15, 2011 | | | |
| | At 7:00 p.m., on | 4/4/11 the "Nurses | | | | | | |
| | Notes" indicated | the resident's SaO2 | | | | | | |
| | | %-94% with O2 at 2 | | | | | | |
| | LPM. | | | | | | | |
| | 1.71 141. | | | | | | | |
| | 0 4/5/11 1 1 2 | 0.00 | | | | | | |
| | |) a.m., SaO2 was 92% | | | | | | |
| | per "Nurses Note | es." | | | | | | |
| | | | | | | | | |
| | On 4/5/11 at 9:30 | a.m., the "Nurses | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155543 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | i i | E SURVEY PLETED (2011 | |
|--|--|--|---------------------|--|-----------------------------|----------------------|
| NAME OF PROVIDE | | | 1425 G | ADDRESS, CITY, STATE, ZIP O RANT ST NGTON, IN46750 | CODE | |
| · · | EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| letha | | the resident was levels were 92% on 2 annula. | | | | |
| a.m., sound lobes treatr The 'Asse: 2011 treatr on 4/ treatr readr An ir on 6/ was u fully | indicated the ds were coans. An "as ne ment was give 'Respiratory ssment/Trea, indicated the ment and ass 5/11 at 11:0 ment the resinission from the review with 21/11 at 11:1 | es," dated 4/5/11 at 11:00 e resident's breath rese through-out bilateral eded" respiratory ven per previous order. Breathing tment Log" for April ne first respiratory ressment was completed 0 a.m. This was the only ident received until after in the hospital. the Director of Nursing 05 a.m., indicated she my the resident was not | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155543 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 06/23/2011 | | | |
|---|--|---|---------------------|--|--------------------------------------|
| HICKOR | PROVIDER OR SUPPLIER Y CREEK AT HUNT | INGTON | 1425 G | ADDRESS, CITY, STATE, ZIP CODE FRANT ST NGTON, IN46750 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE |
| F0329 SS=D | from unnecessary drug is any drug without adequate in the presence of according to the presence of the prese | | F0329 | F329 It is the policy of this fa to ensure each resident's dru regimen will be free from unnecessary drugs. What corrective action will be done the facility? An appointment been set for July 14, 2011 who resident #6 will be evaluated psychiatric consultant includi medication review. How will facility identify other resident having the potential to be affective action will be taken? The Director of Nursing has reviewed the medical record all residents receiving antipsychotic medications. A residents have had attempts gradual dose reductions unless the same productions unless the same productions. | e by has here by a ng the s ected at |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K67311

Facility ID:

000346

If continuation sheet

Page 10 of 19

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE COMPL | | |
|--|---------------------|---|------------|--------------|--|----------|--------------------|
| AND PLAN | OF CORRECTION | 155543 | A. BUI | LDING | 00 | 06/23/2 | |
| | | 199949 | B. WIN | | | 00/23/2 | 011 |
| NAME OF | PROVIDER OR SUPPLIE | 3 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| HICKOR | Y CREEK AT HUNT | INGTON | | 1 | RANT ST NGTON, IN46750 | | |
| | | | | <u> </u> | 101011, 11140700 | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | DATE |
| | | disorder, chronic | 1 | 0 | has been documented by the | <i>,</i> | Dille |
| | 1 ^ | nonary disease, high blood | | | attending physician that a gra | | |
| | pressure, and gla | | | | dose reduction is | | |
| | pressure, and gra | aucoma. | | | contraindicated.The pharmac | - | |
| | The physician or | rders were reviewed. The | | | consultant reviews medication regimens monthly to ensure |)[] | |
| | 1 ' | eiving the following | | | gradual dosage reductions for | ollow | |
| | 1 | edications: Thorazine 25 | | | established guidelines. What | _ | |
| | 1 | four times daily, | | | measures will be put into pla | | |
| | • • • • | g twice daily and 200 mg | | | ensure this practice does not recur? The Director of Nursir | | |
| | 1 ' | xin 7.5 mg twice daily | | | will audit all newly obtained | ·9 | |
| | 1 | dtime, and Zyprexa 10 | | | Physician orders for antipsyc | | |
| | 1 | addition he was receiving | | | medications to ensure there | | |
| | 1 | • | | | diagnosis to support its use. audits will be completed five | | |
| | 1 - | our times a day and Ativan | | | per week for four weeks, thre | | |
| | 1 - | and 2 mg at bedtime for | | | days per week for four week | | |
| | 1 - | s also receiving Lithium | | | then weekly for four weeks. A | | |
| | 1 | nes each day for his | | | results will be forwarded to the | | |
| | 1 - | The orders had been | | | Administrator for review. How corrective action be monitored | | |
| | 1 - | ical doctor and reviewed | | | ensure the deficient practice | | |
| | by a psychologis | St. | | | not recur and what QA will be | e put | |
| | TI :1 . | 1 : 1 16 | | | into place? The Director of | | |
| | 1 | s being tracked for | | | Nursing audit results will be reviewed at the monthly QA8 | 2.Δ | |
| | | included "manipulative | | | committee meeting for 90 da | | |
| | 1 | al aggression, refusal of | | | and until 100% compliance is | 3 | |
| | 1 | g, non-compliance with | | | obtained. Further audits will | | |
| | | policy, knocking on and | | | completed as recommended the QA&A committee.Date of | | |
| | _ | rs doorways to gain staff | | | Compliance: July 15, 2011 | ı | |
| | 1 | other drinks/food, and | | | , , , , | | |
| | | ion." The behavior log | | | | | |
| | 1 | es indicated the resident | | | | | |
| | 1 | l of these behaviors since | | | | | |
| | ~ | nitted to the facility in | | | | | |
| | 1 | is physical aggression had | | | | | |
| | 1 | nitting and kicking a door | | | | | |
| | after he was told | he would have to wait | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | | (X3) DATE S | |
|--|------------------------|------------------------------|---------|----------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155543 | B. WIN | G | | 06/23/20 | 011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| TWINE OF T | KO VIDEK OK SOI I EIEK | | | 1 | RANT ST | | |
| HICKOR' | Y CREEK AT HUNT | INGTON | | HUNTIN | NGTON, IN46750 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TΕ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | | ne was on a water | | | | | |
| | restriction. | | | | | | |
| | | | | | | | |
| | | ata Set assessment, | | | | | |
| | • | 29/11, indicated the | | | | | |
| | | ependent with all of his | | | | | |
| | | living except hygiene. | | | | | |
| | He was ambulate | ory. He weighed 241 | | | | | |
| | pounds and was | 71 inches tall. | | | | | |
| | | | | | | | |
| | Interview with th | ne Director of Nursing | | | | | |
| | (DoN) on 6/22/1 | 1 at 1:45 p.m., indicated | | | | | |
| | the resident had 1 | not been seen by a | | | | | |
| | psychiatrist. She | also indicated she was | | | | | |
| | | long the resident had | | | | | |
| | | nese medications at these | | | | | |
| | _ | sident had been admitted | | | | | |
| | - | t psychiatric hospital | | | | | |
| | • | the area. She also | | | | | |
| | | s not sure what behaviors | | | | | |
| | had necessitated | | | | | | |
| | | e indicated she had | | | | | |
| | | ychologist who had | | | | | |
| | | dent's record. The | | | | | |
| | | icated he would refer the | | | | | |
| | 1 3 | chiatrist if he needed one. | | | | | |
| | resident to a psyc | man ist if he heeded the. | | | | | |
| | 2 1 48(b)(2) | | | | | | |
| | 3.1-48(b)(2) | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | SURVEY | | |
|------------------------------|--|--|---|--------|--|----------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING 00 | | COMPLETED | | |
| 155543 | | 155543 | B. WING | | | 06/23/2 | 011 |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | RANT ST | | |
| HICKORY CREEK AT HUNTINGTON | | | | | NGTON, IN46750 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | _ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | DATE |
| F0406 | If specialized reha | bilitative services such as, | | | | | |
| SS=D | but not limited to, | | | | | | |
| | speech-language | pathology, occupational | | | | | |
| | | al health rehabilitative | | | | | |
| | | al illness and mental | | | | | |
| | | quired in the resident's | | | | | |
| | | an of care, the facility must ed services; or obtain the | | | | | |
| | | from an outside resource (in | | | | | |
| | • | 483.75(h) of this part) from | | | | | |
| | _ | ialized rehabilitative | | | | | |
| | services. | | | | | | |
| | Based on record | review and interview, the | F0 | 406 | F406 It is the policy of this fa | cility | 07/15/2011 |
| | facility failed to | ensure specialized mental | | | to provide specialized | | |
| | health services for | • | | | rehabilitative services such a | S, | |
| | | osychotropic medications | | | but not limited to, physical | | |
| | | | | | therapy, speech-language pathology, occupational thera | anv | |
| | as recommended | • | | | and mental health rehabilitati | | |
| | _ | ation was followed for 1 | | | services for mental illness an | _ | |
| | | rith MR/MI diagnoses in | | | mental retardation, as require | ed. | |
| | a sample of 10 re | esidents. (Resident # 6) | | | What corrective action will be | | |
| | | | | | done by the facility? Resident | | |
| | Findings include |): | | | has a scheduled appointmen psychiatric services on July 1 | | |
| | | | | | 2011. How will the facility iden | | |
| | The clinical reco | rd for Resident # 6 was | | | other residents having the | <u></u> | |
| | reviewed on 6/20 | 0/11 at 10:30 a.m. The | | | potential to be affected by the | <u>e</u> | |
| | | n admitted on 3/23/11 | | | same practice and what | | |
| | | which included, but were | | | corrective action will be taker | | |
| | _ | ipolar disorder, anxiety, | | | residents with Level II Screen | _ | |
| | | • | | | Evaluations have the potential be affected. Level II Screeni | | |
| | impulse control o | | | | Evaluations were reviewed to | • | |
| | • | onary disease, high blood | | | ensure recommendations for | | |
| | pressure, and gla | ucoma. | | | psychiatric services are being | | |
| | | | | | followed. No other residents | | |
| | The Level II Prea | admission Screening | | | were affected. What measure | | |
| | Evaluation was c | completed on 3/5/11. | | | be put into place to ensure th | nis_ | |
| | There were nine | different | | | practice does not recur? The | | |
| | | s made at that time. The | | | Social Services Director or Designee will review all Leve | | |
| | 1 John Marie | 5 mas at that time. The | | | Designee will review all Leve | 1 11 | |

| NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON INDIP SUMMARY STRITMENT OF DEPTICIPACIES TAG REGULATORY OR LSC IDENTIFYING DEPTICIPACIES REGERAL OPERICATION MIST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING DEPOSITION IN TAG recommendations included: "4. It is receive regular psychiatric management of his psychotropic medications" The physician orders were reviewed. The resident was receiving the following psychotropic medications: Thorazine 25 mg (milligrams) four times daily, Scroquel 300 mg twice daily and 200 mg once daily, Prolixin 7.5 mg twice daily and 10 mg at bedtime, and Zyprexa 10 twice daily. In addition he was receiving Buspar 20 mg four times a day and Arivan 1 mg twice daily and 2 mg at bedtime for anxiety. He was also receiving Lithium 450 mg three times cach day for his bipolar disorder. The orders had been signed by a medical doctor and reviewed by a psychologist. The resident was being tracked for behaviors which included "manipulative behaviors, verbal aggression, refusal of care, exit secking, non-compliance with facility smoking policy, knocking on and standing in others doorways to gain staff attention, taking other drinks/food, and physical aggression." The behaviors since having been admitted to the facility in March, 2011. His physical aggression had resulted in him hitting and kicking a door | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155543 | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---------------------|---------------------------------------|----------------------------|-------|--|-----------------------------|-------|
| STREET ADDRESS, CITY, STATE, APPCODE HICKORY CREEK AT HUNTINGTON IMAJ D SUMMARY STATEMENT OF DEPICENCIES PREFIX GACH DEFICIENCY MUST BE PERCEDED BY PLL TAG REGULATORY OR ISC IDENTIFYING DEPROMATIONS, recommendations included.* "4. It is recommended that (Resident # 6's name) receive regular psychiatric management of his psychotropic medications" The physician orders were reviewed. The resident was receiving the following psychotropic medications: Thorazine 2.5 mg (milligrams) four times daily, Scroquel 300 mg twice daily and 200 mg once daily, Prolixin 7.5 mg twice daily and 10 mg at bedtime, and Zyprexa 10 twice daily. In addition he was receiving Buspar 20 mg four times a day and Ativan 1 mg twice daily and 2 mg at bedtime for anxiety. He was also receiving Lithium 450 mg three times each day for his hipolar disorder. The orders had been signed by a medical doctor and reviewed by a psychologist. The resident was being tracked for behaviors, verbal aggression, refusal of care, exit secking, non-compliance with facility smoking policy, knocking on and standing in others doorways to gain staff attention, taking other drinks/food, and physical aggression." The behaviors log and drusing hores indicated the resident had displayed all of these behaviors since having been admitted to the facility in March, 2011. His physical aggression had | | | | A. BUI | LDING | 00 | | |
| HICKORY CREEK AT HUNTINGTON SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION recommended that (Resident # 6's name) receive regular psychiatric management of his psychotropic medications" The physician orders were reviewed. The resident was receiving the following psychotropic medications: Thorazine 25 mg (milligrams) four times daily, Scroquel 300 mg twice daily and 200 mg once daily, Prolixin 7.5 mg twice daily and 200 mg once daily, In addition he was receiving Buspar 20 mg four times a day and Ativan 1 mg twice daily and 2 mg at bedtime for anxiety. He was also receiving Lithium 450 mg three times each day for his bipolar disorder. The orders had been signed by a medical doctor and reviewed by a psychologist. The resident was being tracked for behaviors with included "manipulative behaviors, verbal aggression, refusal of care, exit seeking, non-compliance with facility smoking policy, knocking on and standing in others doorways to gain staff attention, taking other drinks/food, and physical aggression." The behavior log and nursing notes indicated the resident had displayed all of these behaviors since having been admitted to the facility in March, 2011. His physical aggression had | | | 133343 | B. WIN | | | 00/23/2 | 011 |
| HICKORY CREEK AT HUNTINGTON IXAJID SUMMARY STATEMENT OF DETICINCINS TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Tecommendations included: "4. It is recommendations included: "4. It is recommended that (Resident # 6's name) receive regular psychiatric management of his psychotropic medications" The physician orders were reviewed. The resident was receiving the following psychotropic medications: Thorazine 25 mg (milligrams) four times daily, Seroquel 300 mg twice daily and 200 mg once daily, Prolixin 7.5 mg twice daily and 10 mg at bedtime, and Zyprexa 10 twice daily. In addition he was receiving Buspar 20 mg four times a day and Ativan 1 mg twice daily and 2 mg at bedtime for anxiety. He was also receiving Lithium 450 mg three times each day for his bipolar disorder. The orders had been signed by a medical doctor and reviewed by a psychologist. The resident was being tracked for behaviors which included "manipulative behaviors, verbal aggression, refusal of care, exit seeking, non-compliance with facility smoking policy, knocking on and standing in others doorways to gain staff attention, taking other drinks/food, and physical aggression." The behavior log and nursing notes indicated the resident had displayed all of these behaviors since having been admitted to the facility in March, 2011. His physical aggression had | NAME OF | PROVIDER OR SUPPLIE | ₹ | | 1 | | | |
| SUMMARY STATEMENT OF DEFICIENCIES TAG RECEIVED BY FULL RECOIVED BY FULL RECOIVE | HICKORY CREEK AT HI INTINICTON | | | | 1 | | | |
| RECULATORY OF LISC IDENTIFYING INFORMATION) Tecommendations included: "4. It is recommended that (Resident # 6's name) receive regular psychiatric management of his psychotropic medications" The physician orders were reviewed. The resident was receiving the following psychotropic medications: Thorazine 25 mg (milligrams) four times daily, Seroquel 300 mg twice daily and 200 mg once daily, Prolixin 7.5 mg twice daily and 10 mg at bedtime, and Zyprexa 10 twice daily. In addition he was receiving Buspar 20 mg four times a day and Ativan 1 mg twice daily and 2 mg at bedtime for anxiety. He was also receiving Lithium 450 mg three times each day for his bipolar disorder. The orders had been signed by a medical doctor and reviewed by a psychologist. The resident was being tracked for behaviors which included "manipulative behaviors, verbal aggression, refusal of care, exit seeking, non-compliance with facility smoking policy, knocking on and standing in other drinks/food, and physical aggression." The behavior log and nursing notes indicated the resident had displayed all of these behaviors since having been admitted to the facility in March, 2011. His physical aggression had | | | | - | | 10.011, 11.10700 | | (7/5) |
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| recommended that (Resident # 6's name) receive regular psychiatric management of his psychotropic medications" The physician orders were reviewed. The resident was receiving the following psychotropic medications: Thorazine 25 mg (milligrams) four times daily, Seroquel 300 mg twice daily and 200 mg once daily, Prolixin 7.5 mg twice daily and 10 mg at bedtime, and Zyprexa 10 twice daily. In addition he was receiving Buspar 20 mg four times a day and Ativan 1 mg twice daily and 2 mg at bedtime for anxiety. He was also receiving Lithium 450 mg three times each day for his bipolar disorder. The orders had been signed by a medical doctor and reviewed by a psychologist. The resident was being tracked for behaviors which included "manipulative behaviors, verbal aggression, refusal of care, exit seeking, non-compliance with facility smoking policy, knocking on and standing in others doorways to gain staff attention, taking other drinks/food, and physical aggression." The behavior log and nursing notes indicated the resident had displayed all of these behaviors since having been admitted to the facility in March, 2011. His physical aggression had | | recommendation | ns included: " 4 It is | | | recommendations at the time | e the | |
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| having been admitted to the facility in March, 2011. His physical aggression had | | | | | | | | |
| March, 2011. His physical aggression had | | | | | | | | |
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| I reparted in thin titting and kicking a door | | | | | | | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | 00 00 | l l | LETED |
|--|----------------------|---|---------------------------------|---|----------|--------------------|
| | | 155543 | B. WING | | 06/23/2 | 2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | l l | ADDRESS, CITY, STATE, ZIP CODI | Ξ | |
| HICKOB, | Y CREEK AT HUNT | INGTON | l l | RANT ST NGTON, IN46750 | | |
| | | | | 101011, 11140700 | | Q(5) |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU | LD BE | (X5) COMPLETION |
| TAG | · · | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPF DEFICIENCY) | ROPRIATE | DATE |
| | after he was told | he would have to wait | | | | |
| | for his ice since l | ne was on a water | | | | |
| | restriction. | | | | | |
| | | | | | | |
| | Interview with th | ne Director of Nursing | | | | |
| | | 1 at 1:45 p.m., indicated | | | | |
| | | not been seen by a | | | | |
| | | also indicated she was | | | | |
| | | long the resident had | | | | |
| | _ | nese medications at these | | | | |
| | _ | sident had been admitted | | | | |
| | _ | t psychiatric hospital | | | | |
| | | the area. She indicated | | | | |
| | _ | o the psychologist who resident's record. The | | | | |
| | | icated he would refer the | | | | |
| | | chiatrist if he needed one. | | | | |
| | resident to a psyc | amatrist if he needed one. | | | | |
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| | 3.1-23(a)(2) | | | | | |
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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CC | 3) DATE SURVEY | | |
|--|--|--|------------------|---|---------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155543 | | IDENTIFICATION NUMBER: | A DITH DDIC | 00 | COMPLETED | |
| | | A. BUILDING B. WING | 06/23/2011 | | | |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | l | RANT ST | | |
| HICKOR' | Y CREEK AT HUNT | INGTON | | NGTON, IN46750 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| F0441 SS=D | Infection Control F a safe, sanitary an and to help prever transmission of dis (a) Infection Contr The facility must e Program under wh (1) Investigates, co infections in the fa (2) Decides what p isolation, should b resident; and (3) Maintains a rec corrective actions (b) Preventing Spr | establish an Infection Control nich it - ontrols, and prevents cility; procedures, such as e applied to an individual cord of incidents and related to infections. | | | | |
| | determines that a prevent the spread must isolate the re (2) The facility must communicable dis lesions from direct their food, if direct disease. (3) The facility must hands after each of which hand washing professional practice. | resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin t contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted ice. | | | | |
| | transport linens so as to prevent the spread of infection. Based on observation, interview and | | F0441 | F 441 It is the policy of this for | | |
| | maintain infection of 1 residents (Re | ne facility failed to on control practices for 1 esident C) observed for in a sample of 10. | | to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help pre | | |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|------------------------------|--|---------------------------------------|----------------------------|----------------------------------|--|------------|--------------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING 00 | | 00 | COMPLETED | |
| 15 | | 1555/3 | | B. WING | | 06/23/2011 | |
| | | Ш | | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF PROVIDER OR SUPPLIER | | | | 1425 G | RANT ST | | |
| | Y CREEK AT HUNT | | _ | | NGTON, IN46750 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) COMPLETION |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIATE | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | + | TAG | | | DATE |
| | Finding includes | : | | | the development and transmission of disease and infection. What corrective acwill be done by the facility? | tion_ | |
| | Resident C's clin | nical record was reviewed | | | Nursing staff will be inservice | ed by | |
| | on 6/20/11 at 10: | :45 a.m. Diagnosis | | | the Director of Nursing on Ju | | |
| | included but wer | · · | | | and July 8, 2011 to review th | | |
| | | tension, depression, | | | correct procedures for cathet | | |
| | | anemia, esophageal reflux | | | care and peri-care. Nursing s will then perform a return | siaii | |
| | _ | | | | demonstration using proper | | |
| | disease, and Stage III pressure ulcer. | | | | technique following the | | |
| | An observation | was conducted on 6/21/11 | | | established policies. <u>How will</u> | | |
| | | | | | facility identify other resident | | |
| | _ | Resident C receiving | | | having the potential to be affective | | |
| | catheter/pericare | | | | by the same practice and whe corrective action will be taken | | |
| | | | | | residents have the potential t | _ | |
| | | s turned to her left side | | | affected; no other residents v | | |
| | | e bed. She was observed | | | negatively affected. What | | |
| | to have a loose d | lressing covering her | | | measures will be put into pla | | |
| | pressure ulcer w | hich was located on the | | | ensure this practice does not | _ | |
| | medial aspect of | her right buttock. | | | <u>recur?</u> Random observations peri-care/catheter care will be | | |
| | Certified Nursing | g Assistant (CNA) #1 was | | | completed by the Director of | | |
| | handed a very w | et wash cloth from CNA | | | Nursing or Designee five time | | |
| | 1 | d the wet wash cloth | | | per week for four weeks, the | | |
| | | lent's buttock and | | | three times per week for four | | |
| | | ter from the wash cloth | | | weeks, then one time per we for four weeks. An employee | | |
| | down over the re | | | | fails to follow the correct | WITO | |
| | | · · · · · · · · · · · · · · · · · · · | | | procedure will be re-inservice | ed | |
| | including over and under the loose dressing. She then wiped the resident's buttocks with the wash cloth but not near the loose dressing. She also washed the | | | | and progressive disciplinary | | |
| | | | | | action rendered as deemed | | |
| | | | | | necessary. Results of the | | |
| | | | | | observations will be reported the Administrator. How will | ιΟ | |
| | | rea and then dried the | | | corrective action be monitore | ed to | |
| | | ea with a dry towel. The | | | ensure the deficient practice | | |
| | | eport to a licensed nurse | | | not recur and what QA will be | | |
| | that the dressing | was loose and had | | | into place? Results of the | | |
| | become wet duri | ng care. | | | observations will be forwarde | ed to | |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) | | (X3) DATE S | X3) DATE SURVEY | |
|-----------------------------|--|--|---------------------------------|--|---|----------------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | LDING | 00 | COMPLETED | |
| | | 155543 | B. WIN | | | 06/23/2 | 011 |
| | | | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | ļ | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | RANT ST | | |
| HICKORY CREEK AT HUNTINGTON | | | | 1 | NGTON, IN46750 | | |
| | | | | | 101011, 1114-0700 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | , | | DATE |
| TAG | The resident was back, dressed and wheelchair. Both CNA's were completion of the would have done They both replied Nursing was pressed. An interview with Nursing, on 6/21 indicated the CN procedure and the control issue with open wound on hassure that the drequickly. The policy and preceived and revising the work of the washer Cleansing and the back. | e interviewed after e care as to whether they e anything differently. d "No." The Director of sent at this interview. th the Director of /11 at 2:20 p.m., A's had not followed is was an infection the resident having an her buttock. She would ressing was changed | | TAG | the monthly QA&A committee further review and recommendations. When observations have been completed for twelve weeks 100% compliance has been obtained, the QA committee determine the need and frequency for further observations. Date of Compli July 15, 2011 | e for and will | DATE |
| | | | | | | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543 | A. BUILDING B. WING | 00 | COMP 06/23/2 | LETED |
|-----------------------------|-----------------------------|---|---------------------|---|-------------------------------|--------------------|
| NAME OF P | PROVIDER OR SUPPLIER | | STREET A | ADDRESS, CITY, STATE, ZIP COL | DE | |
| HICKORY CREEK AT HUNTINGTON | | | | RANT ST NGTON, IN46750 | | |
| (X4) ID PREFIX | SUMMARY S (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ECTION ULD BE PROPRIATE | (X5) COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE |
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